MassHealth Senior Care Options Enrollment Form

SCO
Senior Care Options

Office Use Only

Date Received

Effective Date

Please print clearly. Fill out all sections. If you need help with this form, call the senior care organization that you want to join, or the Senior Care Options Unit at 1-888-885-0484.

Do you have End Stage Renal Disease (ESRD)? ESRD means permanent kidney failure.
Yes ☐ No ☐

If you answered Yes to this question, you cannot enroll in SCO.

Which senior care organization do you want to join? If you need information about senior care organizations in your area, please contact the Senior Care Options Unit at 1-888-885-0484.

Name of primary care doctor you have selected

Applicant/member information

Last Name | First Name | MI

Social Security Number | Date of Birth | Sex M ☐ F ☐

Written Language Preferred | Spoken Language Preferred

Permanent Address (where you live)
Street Address | City/Town

State | Zip Code | Telephone Number

Mailing Address (where you get mail, if different from where you live)
Street Address | City/Town

State | Zip Code | Telephone Number

If you are a resident of an institution, enter the name and address of the institution.

Street Address | City/Town

State | Zip Code | Telephone Number

MassHealth Information

Please write in your MassHealth ID number or attach a copy of your MassHealth card. Your MassHealth number is the number **beside** your name.

_____
MassHealth ID Number

You must be in the MassHealth Program to enroll in a senior care organization.

Medicare Information

Please fill in the blanks so they look the same as what is on your Medicare card. You must fill this out or attach a copy of your Medicare card or your letter of verification from the Social Security Administration or the Railroad Retirement Board.

Medicare Health Insurance
Social Security Act

Name of Beneficiary_____

Medicare Claim Number _____ Sex _____

Is Entitled to: Effective Date:
_____Hospital Insurance (Part A) _____
_____Medical Insurance (Part B)

Other Health Insurance

Do you have any health insurance other than Medicare and MassHealth?

Yes ☐ No ☐

If you answered Yes, what is the name of the other insurance?

_____

Your Medical Care

By joining SCO, I agree that:

1. I must follow all the rules in my SCO Enrollment Agreement.
2. I must choose a primary doctor from the list of participating primary care doctors.
3. My primary doctor will provide all of my routine medical care.
4. My primary doctor will coordinate all of my speciality care.
5. I will have to get my medical care solely from the senior care organization's network of doctors, clinics, hospitals and other care providers.
6. In the case of an emergency or urgent-care situation, I may visit any doctor or emergency room.
7. I will start receiving my medical care from the SCO on the date that MassHealth tells me my SCO health care begins.
8. I can leave (disenroll from) the senior care organization by sending a written request to the senior care organization. I must keep getting my medical care from the senior care organization until the date of my disenrollment.
9. If I move my residence, I must notify the senior care organization and MassHealth.
10. I have rights to appeal if the senior care organization denies my request for medical services or payment.
11. I understand by enrolling in this plan that I will automatically be disenrolled from any other Medicare+ Choice plan.

Release of Information

By joining this plan, I allow the Centers for Medicare and Medicaid Services (CMS) and MassHealth to give information about my Medicare and MassHealth coverage to the senior care organization. The senior care organization may also provide information about me to CMS and MassHealth in order to run the Medicare and MassHealth programs.

Signature

I understand that my signature on this application means that I have read and understand the contents of this application. I certify under the penalties of perjury that the information provided in the application is complete and correct to the best of my ability.

Signature:_____ Date:_____

If you are signing this application on the applicant's behalf, you must certify that you are responsible for the applicant and are authorized to enroll the applicant in a senior care organization. If you have written authorization for the applicant to serve as his/her eligibility representative, please attach a copy, if available. If you have been appointed by a court to act as legal guardian or conservator for an applicant who is unable to complete the form because of a physical or mental condition, please attach a copy of the appointment, if available.

Printed Name and Address of Eligibility Representative if signing above:

_____

_____

_____

_____

Eligibility Representative Signature:_____

NOTES